

STATEMENT OF EMERGENCY
803 KAR 25:195E

(1) KRS 342.020(1) requires employers to pay for reasonable and necessary medical treatment for the cure and relief from the effects of a work-place injury or occupational disease. KRS 342.020(4) requires the employer to pay the medical provider within thirty (30) days of receipt of a statement for services and requires the commissioner to promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. KRS 342.020(4) further requires the commissioner to promulgate administrative regulations with procedures by which disputes regarding the necessity, effectiveness, frequency, and cost of treatment may be resolved. Utilization review is a procedure by which medical treatment may be evaluated for reasonableness and necessity and disputes may be resolved; the thirty (30) day period for payment is tolled while a treatment is undergoing utilization review.


Additionally, KRS 342.020(7)(f) requires employers with a managed care system to establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee. KRS 342.035(5)(c) requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342.

During the 2017 session of the General Assembly, KRS Chapter 13A was amended to state that administrative regulations shall expire seven (7) years after the last effective date. KRS 342.190 was due to expire unless the regulations compiler was notified that the Department of Workers' Claims had reviewed the administrative regulation and certified its desire to keep the administrative regulation in effect or notified the regulations compiler it would amend the administrative regulation; the Department notified the regulations compiler of its intent to amend 803 KAR 25:190. An amendment to 803 KAR 25:190 was filed February 18, 2021, and found deficient by the Administrative Regulation Review Subcommittee during its meeting on November 9, 2021. Governor Andy Beshear determined 803 KAR 25:190 was effective notwithstanding the finding of deficiency. The General Assembly passed Senate Bill 65 on April 13, 2022, over the Governor's veto. Senate Bill 65 provides that 803 KAR 25:190, as amended, expires if not adopted by the time the bill was enacted or, if it had been adopted by the time the bill was enacted, then 803 KAR 25:190 is null, void, and unenforceable at the time the bill was enacted.

In contravention to the statutory requirements of KRS Chapter 342, no administrative regulation is in effect to govern medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342. Additionally, it is not possible to have an ordinary administrative regulation become effective in time to meet these statutory requirements.

(2) The guidance provided in this emergency administrative regulation cannot be provided through an ordinary administrative regulation because the ordinary rulemaking process cannot be completed in time to meet the statutory requirements..

(3) This emergency administrative regulation will be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.



Andy Beshear
Governor



Jamie Link
Secretary of the Labor Cabinet

1 LABOR CABINET

2 Department of Workers' Claims

3 (Emergency Administrative Regulation)

4 803 KAR 25:195E. Utilization review, Appeal of Utilization Review Decisions, and Medical Bill
5 Audit

6 RELATES TO: KRS Chapter 342

7 STATUTORY AUTHORITY: KRS 342.035(5) and (6), 342.260

8 NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the
9 Commissioner of the Department of Workers' Claims shall promulgate administrative regulations
10 necessary to carry on the work of the Department of Workers' Claims, and the commissioner may
11 promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342.
12 KRS 342.035(5) requires the commissioner to promulgate administrative regulations governing
13 medical provider utilization review activities conducted by an insurance carrier, group self-insurer
14 or self-insured employer pursuant to KRS Chapter 342. KRS 342.035(5) provides the
15 commissioner of the Department of Workers' Claims shall promulgate administrative regulations
16 that require each insurance carrier, group self-insurer and individual self-insured employer to
17 certify to the commissioner the program it has adopted to insure compliance with the medical fee
18 schedule provisions of KRS 342.035(1) and (4). KRS 342.035(8) requires the commissioner to
19 adopt or develop a pharmaceutical formulary and treatment guidelines; utilization review assists

1 in the proper implementation of the pharmaceutical formulary and treatment guidelines. This
2 administrative regulation insures that insurance carriers, group self-insurers, and individual
3 self-insured employers implement a utilization review and medical bill audit program.

4 Section 1. Definitions. (1) "Business day" means any day except Saturday, Sunday
5 or any day which is a legal holiday.

6 (2) "Calendar day" means all days in a month, including Saturday, Sunday and any
7 day which is a legal holiday.

8 (3) "Carrier" is defined by KRS 342.0011(6).

9 (4) "Commissioner" is defined by KRS 342.0011(9).

10 (5) "Denial" means a determination by the utilization reviewer that the medical
11 treatment, proposed treatment, service, or medication under review is not medically necessary
12 or appropriate and, therefore, payment is not recommended.

13 (6) "Department" is defined by KRS 342.0011(8).

14 (7) "Medical bill audit" means the review of medical bills for services which have
15 been provided to assure compliance with adopted fee schedules.

16 (8) "Medically necessary" or "medical necessity" means healthcare services,
17 including medications, that a medical provider, exercising prudent clinical judgment, would
18 provide to a patient for the purpose of preventing, evaluating, diagnosing or treating, an
19 illness, injury, disease or its symptoms, and that are:

20 1. In accordance with generally accepted standards of medical practice;

21 2. Clinically appropriate, in terms of type, frequency, extent site and duration; and

1 3. Considered effective for the patient's illness, injury, or disease.

2 (9) "Medical payment obligor" means any employer, carrier, insurance carrier, self-
3 insurer, or any person acting on behalf of or as an agent of the employer, carrier, insurance
4 carrier, or self-insurer.

5 (10) "Medical provider" means physicians and surgeons, psychologists, optometrists,
6 dentists, podiatrists, osteopathic and chiropractic practitioners, physician assistants, and
7 advanced practice registered nurses, acting within the scope of their license

8 (11) "Physician" is defined by KRS 342.0011(32).

9 (12) "Preauthorization" means a process whereby payment for a medical service or
10 course of treatment is assured in advance by a carrier.

11 (13) "Utilization review" means a review of the medical necessity and appropriateness
12 of medical care and services for purposes of recommending payments for a compensable
13 injury or disease.

14 (14) "Utilization review and medical bill audit plan" means the written plan submitted
15 to the commissioner by each medical payment obligor describing the procedures governing
16 utilization review and medical bill audit activities.

17 (15) "Vendor" means a person or entity which implements a utilization review and
18 medical bill audit program for purposes of offering those services to carriers.

19 Section 2. Utilization Review and Medical Bill Audit Program. (1) The utilization
20 review program shall assure that:

21 (a) A utilization reviewer is appropriately qualified;

1 (b) Treatment rendered to an injured worker is medically necessary and appropriate;
2 and

3 (c) Necessary medical services are not withheld or unreasonably delayed.

4 (2) The medical bill audit program shall assure that:

5 (a) A statement or payment for medical goods and services and charges for a
6 deposition, report, or photocopy comply with KRS Chapter 342 and 803 KAR Chapter 25;

7 (b) A medical bill auditor is appropriately qualified; and

8 (c) A statement for medical services is not disputed without reasonable grounds.

9 Section 3. Utilization Review and Medical Bill Audit Plan Approval. (1) A medical
10 payment obligor shall fully implement and maintain a utilization review and medical bill
11 audit program.

12 (2) A medical payment obligor shall provide to the commissioner a written plan
13 describing the utilization review and medical bill audit program. The commissioner shall
14 approve each utilization review and medical bill audit plan which complies with the
15 requirements of this administrative regulation and KRS Chapter 342.

16 (3) A vendor shall submit to the commissioner for approval a written plan describing
17 the utilization review and medical bill audit program. Upon approval, the vendor shall receive
18 written notice from the commissioner.

19 (4) A medical payment obligor who contracts with an approved vendor for utilization
20 review or medical bill audit services shall notify the commissioner of the contractual

1 arrangement. The contractual arrangement may provide for separate utilization review and
2 medical bill audit vendors.

3 (5) A plan shall be approved for a period of four (4) years.

4 (a) At least ninety (90) calendar days prior to the expiration of the period of approval,
5 a medical payment obligor or its approved vendor shall apply for renewal of the approval.

6 (b) During the term of an approved plan, the commissioner shall be notified as soon
7 as practicable of a material change in the approved plan or a change in the selection of a
8 vendor.

9 (6) A carrier who contracts with an approved vendor for utilization review services
10 shall provide annually to the commissioner summaries of the number of utilization reviews
11 conducted, utilization reviews waived in accordance with KRS 342.035(5)(c), utilization
12 reviews resulting in an approval, and utilization reviews resulting in a denial. The annual
13 report of the approved vendor shall be filed with the commissioner no later than August 1 for
14 the preceding year, including any fiscal year ending on or before June 30.

15 Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The
16 written utilization review and medical bill audit plan submitted to the commissioner shall
17 include the following elements:

18 (1) A description of the process, policies and procedures for making decisions;

19 (2) A statement that medical treatment guidelines adopted by the commissioner
20 pursuant to KRS 342.035 (8)(a) shall be incorporated in the plan as the standard for utilization
21 review medical decision making;

1 (3) A description of the criteria by which claims, medical services and medical bills
2 shall be selected for review;

3 (4) A description of the:

4 (a) Qualifications of internal and consulting personnel who shall conduct utilization
5 review and medical bill audit; and

6 (b) The manner in which the personnel shall be involved in the review process;

7 (5) A description of the process to assure that a treatment plan shall be obtained for
8 review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

9 (6) A description of the process to assure that a physician shall be designated by each
10 injured employee as required under 803 KAR 25:096;

11 (7) A description of the process for rendering and promptly notifying the medical
12 provider and employee of the initial utilization review decision;

13 (8) A description of the reconsideration process within the structure of the utilization
14 review and medical bill audit program;

15 (9) An assurance that a database shall be maintained, which shall:

16 (a) Record:

17 1. Each instance of utilization review;

18 2. Each instance of medical bill audit;

19 3. The name of the reviewer;

20 4. The extent of the review;

1 5. The conclusions of the reviewer; and

2 6. The action, if any, taken as the result of the review;

3 (b) Be maintained for a period of at least two (2) years; and

4 (c) Be subject to audit by the commissioner, or his agent, pursuant to KRS
5 342.035(5)(b); and

6 (10) A description of the policies and procedures that shall be implemented to protect
7 the confidentiality of patient information.

8 Section 5. Claim Selection Criteria. (1) Unless the medical payment obligor, in good
9 faith, denies the claim as noncompensable or waives utilization review pursuant to KRS
10 342.035 (5)(c), medical services reasonably related or asserted to be related to the claim shall
11 be subject to utilization review if:

12 (a) A medical provider requests preauthorization of a medical treatment or procedure;

13 (b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR
14 25:096 treatment plan is received;

15 (c) The total medical costs cumulatively exceed \$3000;

16 (d) The total lost work days cumulatively exceed thirty (30) days; or

17 (e) An administrative law judge orders a review.

18 (2) Utilization review shall commence when the medical payment obligor has notice
19 that a claims selection criteria has been met. The medical payment obligor may waive
20 utilization review pursuant to KRS 342.035(5)(c) within two (2) business days of notice that
21 a claims selection criteria has been met.

1 (a) The following requirements shall apply if preauthorization has been requested and
2 utilization review has not been waived by the medical payment obligor:

3 1. The initial utilization review decision shall be communicated to the medical
4 provider and employee within two (2) business days of the initiation of the utilization review
5 process, unless additional information is required. If additional information is required, a
6 single request shall be made within two (2) additional business days.

7 2. The requested information shall be submitted by the medical provider within ten
8 (10) business days.

9 3. The initial utilization review decision shall be rendered and communicated within
10 two (2) business days following receipt of the requested information.

11 (b) The following requirements shall apply if retrospective utilization review occurs:

12 1. The initial utilization review decision shall be communicated to the medical
13 provider and employee within ten (10) calendar days of the initiation of the utilization review
14 process, unless additional information is required. If additional information is required, a
15 single request shall be made within two (2) additional business days.

16 2. The requested information shall be submitted by the medical provider within ten
17 (10) business days.

18 3. The initial utilization review decision shall be rendered within two (2) business
19 days following receipt of the requested information.

20 (3) A medical provider may request an expedited utilization review determination for
21 proposed medical treatment or services, the lack of which could reasonably be expected to
22 lead to serious physical or mental disability or death. The expedited utilization review

1 determination shall be rendered and communicated within twenty-four (24) hours following
2 a request for expedited review.

3 (4) Initiation of utilization review shall toll the thirty (30) day period for challenging
4 or paying medical expenses pursuant to KRS 342.020(4). The thirty (30) day period for
5 paying medical expenses shall commence on the date of the final utilization review decision.

6 (5) Each medical bill audit shall be initiated within seven (7) calendar days of receipt
7 to assure:

8 (a) Compliance with applicable fee schedules, in accordance with 803 KAR Chapter
9 25;

10 (b) Accuracy; and

11 (c) That a physician has been designated in accordance with 803 KAR 25:096.

12 (6) A medical bill audit shall not toll the thirty (30) day period for challenging or
13 paying medical expenses pursuant to KRS 342.020(4).

14 Section 6. Utilization Review and Medical Bill Audit Personnel Qualifications. (1)
15 Utilization review personnel shall have education, training, and experience necessary for
16 evaluating the clinical issues and services under review. The following professionals shall
17 issue an initial utilization review approval:

18 (a) A physician;

19 (b) A registered nurse;

20 (c) A licensed practical nurse;

21 (d) A medical records technician; or

1 (e) Other personnel whose training and experience qualify them to issue decisions on
2 medical necessity or appropriateness.

3 (2) Only a physician may issue an initial utilization review denial. A physician shall
4 supervise utilization review personnel in making utilization review recommendations.
5 Personnel shall hold the license required by the jurisdiction in which they are employed.

6 (3) Personnel conducting a medical bill audit shall have the education, training or
7 experience necessary for evaluating medical bills and statements.

8 Section 7. Written Notice of Denial. (1) Following initial review, a written notice of
9 denial shall:

10 (a) Be issued to both the medical provider and the employee in a timely manner but
11 no more than ten (10) calendar days from the initiation of the utilization review process;

12 (b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

13 (c) Contain:

14 1. A statement of the medical reasons for denial;

15 2. The name, state of licensure and medical license number of the reviewer; and

16 3. An explanation of utilization review reconsideration rights.

17 (2) Payment for medical services shall not be denied on the basis of lack of
18 information absent documentation of a good faith effort to obtain the necessary information.

19 Section 8. Reconsideration. (1) A reconsideration process to appeal an initial decision
20 shall be provided within the structure of utilization review.

1 (a) A request for reconsideration of the initial utilization review decision shall be
2 made by an aggrieved party within fourteen (14) calendar days of receipt of a written notice
3 of denial.

4 (b) Reconsideration of the initial utilization review decision shall be conducted by a
5 different reviewer of at least the same qualifications as the medical provider whose treatment
6 is being reconsidered.

7 (c) A written reconsideration decision shall be rendered within ten (10) calendar days
8 of receipt of a request for reconsideration. The written decision shall be clearly entitled
9 "UTILIZATION REVIEW - RECONSIDERATION DECISION". If the reconsideration
10 decision is made by an appropriate specialist or subspecialist, the written decision shall
11 further be entitled "FINAL UTILIZATION REVIEW DECISION".

12 (d) Those portions of the medical record that are relevant to the reconsideration, if
13 authorized by the patient and in accordance with state or federal law, shall be considered and
14 providers shall be given the opportunity to present additional information.

15 (2)(a) If a utilization review denial is upheld upon reconsideration and a board eligible
16 or certified physician in the appropriate specialty or subspecialty area, or a chiropractor
17 qualified pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously reviewed the
18 matter, an aggrieved party may request further review by:

19 1. A board eligible or certified physician in the appropriate specialty or subspecialty;

20 or

21 2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

1 (b) A written decision shall be rendered within ten (10) calendar days of the request
2 for specialty reconsideration. The specialty decision shall be clearly entitled "FINAL
3 UTILIZATION REVIEW DECISION".

4 (3) A reconsideration process to appeal an initial decision shall be provided within
5 the structure of medical bill audit.

6 (a) A request for reconsideration of the medical bill audit decision shall be made by
7 an aggrieved party within fourteen (14) calendar days of receipt of that decision.

8 (b) Reconsideration shall be conducted by a different reviewer of at least the same
9 qualifications as the initial reviewer.

10 (c) A written decision shall be rendered within ten (10) calendar days of receipt of a
11 request for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL
12 AUDIT RECONSIDERATION DECISION".

13 (d) A request for reconsideration of the medical bill audit decision shall not toll the
14 thirty (30) day period for challenging or paying medical expenses pursuant to KRS
15 342.020(1).

16 Section 9. Peer-to-Peer Conference. (1) If the medical payment obligor denies
17 preauthorization following utilization review, it shall issue a written notice of denial as
18 required in Section 7 of this administrative regulation. The medical provider whose
19 recommendation for treatment is denied may request reconsideration, and may require the
20 reconsideration include a peer-to-peer conference with a second utilization review physician.
21 The request for a peer-to-peer conference shall be made by electronic communication and
22 shall provide:

1 (a) A telephone number for the reviewing physician to call;

2 (b) A date or dates for the conference not less than five (5) business days after the
3 date of the request; and

4 (c) A one (1)-hour period during the date or dates specified during which the
5 requesting medical provider, or a designee, will be available to participate in the conference
6 between the hours of 8:00 a.m. and 6:00 p.m. (Eastern Time), Monday through Friday.

7 (4) The reviewing physician participating in the peer-to-peer conference shall be of
8 the same specialty as the medical provider requesting reconsideration.

9 (5) Failure of the reviewing physician to participate during the date and time specified
10 shall result in the approval of the request for preauthorization and approval of the
11 recommended treatment unless good cause exists for the failure to participate. In the event of
12 good cause for failure to participate in the peer-to-peer conference, the reviewing physician
13 shall contact the requesting medical provider to reschedule the peer-to-peer conference. The
14 rescheduled peer-to-peer conference shall be held no later than two (2) business days
15 following the original conference date. Failure of the requesting medical provider or its
16 designee to participate in the peer-to-peer conference during the time he or she specified
17 availability may result in denial of the request for reconsideration.

18 (6) A written reconsideration decision shall be rendered within five (5) business days
19 of date of the peer-to-peer conference. The written decision shall be entitled "FINAL
20 UTILIZATION REVIEW DECISION."

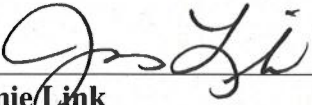
21 (7) If a Final Utilization Review Decision is rendered denying authorization for
22 treatment before an award has been entered by or agreement approved by an administrative
23 law judge, the requesting medical provider or the injured employee may file a medical dispute
24 pursuant to 803 KAR 25:012. If a Final Utilization Review Decision is rendered denying

1 authorization for treatment after an award has been entered by or agreement approved by an
2 administrative law judge, the employer shall file a medical dispute pursuant to 803 KAR
3 25:012.

4 (8) Pursuant to KRS 342.285(1), a decision of an administrative law judge on a
5 medical dispute is subject to review by the workers' compensation board under the
6 procedures set out in 803 KAR 25:010, Section 22.

7

This is to certify the Secretary has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 342.260, 342.270 and 342.285.



Jamie Link
Secretary of the Labor Cabinet

04/14/2022

Date

CONTACT PERSON: B. Dale Hamblin, Jr., Assistant General Counsel
Workers' Claims Legal Division
Mayo-Underwood Building, 3rd Floor
500 Mero Street
Frankfort, Kentucky 40601
Telephone Number: (502) 782-4404
Fax Number: (502) 564-0682
dale.hamblin@ky.gov

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this emergency administrative regulation shall be held on May 31, 2022, at 10:00 a.m. (EDT) at the Department of Workers' Claims, 500 Mero Street, Frankfort, KY 40601. In keeping with KRS 13A.270, individuals interested in attending or being heard at this hearing shall notify this agency in writing of their intent to attend no later than five (5) workdays prior to the hearing along with contact information. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed emergency administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed emergency administrative regulation. Written comments shall be accepted through May 31, 2022. Send written notification of intent to be heard at the public hearing or written comments on the proposed emergency administrative regulation to the contact person

CONTACT PERSON:

B. Dale Hamblin, Jr.
Assistant General Counsel
Department of Workers' Claims
Mayo-Underwood Building, 3rd Floor
500 Mero Street
Frankfort, Kentucky 40601
Telephone Number: (502) 782-4404
Fax Number: (502) 564-0681
Dale.Hamblin@ky.gov

1

2

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation: 803 KAR 25:195E
Contact person: B. Dale Hamblin, Jr.

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This emergency administrative regulation governs medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342.
 - (b) The necessity of this administrative regulation: KRS 342.035(5)(c) requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to KRS Chapter 342.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 342.020 makes employers and their payment obligors responsible for payment of reasonable and necessary medical treatment for the cure and relief of work-place injuries and occupational diseases. Utilization review assists employers and employees in determining whether medical treatment is reasonable and necessary. Additionally, KRS 342.020(7)(f) requires employers with a managed care system to establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee. This regulation provides guidance to stakeholders regarding the requirements of a utilization review program and its implementation.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This emergency administrative regulation provides guidance to stakeholders regarding the requirements of a statutorily required utilization review program and its implementation.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is a new emergency administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: N/A
 - (c) How the amendment conforms to the content of the authorizing statutes: N/A
 - (d) How the amendment will assist in the effective administration of the statutes: N/A
- (3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Insurance carriers, self-insured groups, self-insured employers, and injured employees.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Insurance carriers, self-insured groups, and self-insured employers will be required to have a system of utilization review to assess the reasonableness and necessity of medical treatment. Entities utilizing a managed care organization must include utilization review as part of that program. Employees will receive appropriate medical treatment in a timely manner.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Costs are expected to remain consistent with current costs.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Employers, medical payment obligors, and employees may be assured that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee.
- (5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
- (a) Initially: No additional costs are associated with implementation.
 - (b) On a continuing basis: No additional continuing costs.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement this emergency administrative regulation.
- (8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any new fees or directly or indirectly increase any fees.
- (9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied because the utilization review procedure applies to all parties equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation No. 803 KAR 25:195E

Contact Person: B. Dale Hamblin, Jr.

Phone number: (502) 782-4404

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Workers' Claims and all parts of government with employees.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.020, 342.035, and 342.260.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue will be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No new administrative costs will be required.

(d) How much will it cost to administer this program for subsequent years? No new administrative costs will be required.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

There is no fiscal impact on state or local government because the activities associated with the emergency administrative regulation are currently performed by those entities; however, the same cannot be said absent this emergency administrative regulation.

Documentary Evidence of Emergency

Pursuant to 13A.190(1)(a)3., this emergency administrative regulation is necessary to comply with KRS 342.020(4), (6), (7) and 342.035(5). Both documents are attached.

Additionally, this emergency administrative regulation there is an imminent threat to the health, safety, and welfare of Kentucky's employees. Specifically, without this emergency administrative regulation, there is no assurance that a course of treatment for injured Kentucky employees is reasonably necessary; that diagnostic procedures are not unnecessarily duplicated; that the frequency, scope, and duration of medical treatment is appropriate; that pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee.

342.035 Administrative regulations -- Medical fee schedule -- Review and updating -- Action for excess fees -- Effect of failure to submit to or follow surgical or medical treatment or advice -- Certification to commissioner -- Audit -- Utilization review -- Report -- Copies of records -- Practice parameters and evidence-based guidelines -- Formulary -- Medical fee schedule for registered nurse first assistants.

- (1) Periodically, the commissioner shall promulgate administrative regulations to adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements under KRS 342.020 and this section shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. In determining what fees are reasonable, the commissioner may also consider the increased security of payment afforded by this chapter. On or before November 1, 1994, and on July 1 every two
- (2) years thereafter, the schedule of fees contained in administrative regulations promulgated pursuant to this section shall be reviewed and updated, if appropriate. Within ten (10) days of April 4, 1994, the commissioner shall execute a contract with an appropriately qualified consultant pursuant to which each of the following elements within the workers' compensation system are evaluated; the methods of health care delivery; quality assurance and utilization mechanisms; type, frequency, and intensity of services; risk management programs; and the schedule of fees contained in administrative regulation. The consultant shall present recommendations based on its review to the commissioner not later than sixty (60) days following execution of the contract. The commissioner shall consider these recommendations and, not later than thirty (30) days after their receipt, promulgate a regulation which shall be effective on an emergency basis, to effect a twenty-five percent (25%) reduction in the total medical costs within the program.
- (2) No provider of medical services or treatment required by this chapter, its agent, servant, employee, assignee, employer, or independent contractor acting on behalf of any medical provider, shall knowingly collect, attempt to collect, coerce, or attempt to coerce, directly or indirectly, the payment of any charge, for services covered by a workers' compensation insurance plan for the treatment of a work-related injury or occupational disease, in excess of that provided by a schedule of fees, or cause the credit of any employee to be impaired by reason of the employee's failure or refusal to pay the excess charge. In addition to the penalty imposed in KRS 342.990 for violations of this subsection, any individual who sustains damages by any act in violation of the provisions of this subsection shall have a civil cause of action in Circuit Court to enjoin further violations and to recover the actual damages sustained by the individual, together with the costs of the lawsuit, including a reasonable attorney's fee.
- (3) Where these requirements are furnished by a public hospital or other institution, payment thereof shall be made to the proper authorities conducting it. No compensation shall be payable for the death or disability of an employee if his or her death is caused, or if and insofar as his disability is aggravated, caused, or

continued, by an unreasonable failure to submit to or follow any competent surgical treatment or medical aid or advice.

- (4) The commissioner shall, by December 1, 1994, promulgate administrative regulations to adopt a schedule of fees for the purpose of regulating charges by medical providers and other health care professionals for testimony presented and medical reports furnished in the litigation of a claim by an injured employee against the employer. The workers' compensation medical fee schedule for physicians, 803 KAR 25:089, having an effective date of February 9, 1995, shall remain in effect until July 1, 1996, or until the effective date of any amendments promulgated by the commissioner, whichever occurs first, it being determined that this administrative regulation is within the statutory grant of authority, meets legislative intent, and is not in conflict with the provisions of this chapter. The medical fee schedule and amendments shall be fair, current, and reasonable and otherwise comply with this section.
- (5)
 - (a) To ensure compliance with subsections (1) and (4) of this section, the commissioner shall promulgate administrative regulations by December 31, 1994, which require each insurance carrier, self-insured group, and self-insured employer to certify to the commissioner the program or plan it has adopted to ensure compliance.
 - (b) In addition, the commissioner shall periodically have an independent audit conducted by a qualified independent person, firm, company, or other entity hired by the commissioner, in accordance with the personal service contract provisions contained in KRS 45A.690 to 45A.725, to ensure that the requirements of subsection (1) of this section are being met. The independent person, firm, company, or other entity selected by the commissioner to conduct the audit shall protect the confidentiality of any information it receives during the audit, shall divulge information received during the audit only to the commissioner, and shall use the information for no other purpose than the audit required by this paragraph.
 - (c) The commissioner shall promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to this chapter. Utilization review required under administrative regulations may be waived if the insurance carrier, self-insured group, or self-insured employer agrees that the recommended medical treatment is medically necessary and appropriate or if the injured employee elects not to proceed with the recommended medical treatment.
 - (d) Periodically, or upon request, the commissioner shall report to the Interim Joint Committee on Economic Development and Workforce Investment of the Legislative Research Commission or to the corresponding standing committees of the General Assembly, as appropriate, the degree of compliance or lack of compliance with the provisions of this section and make recommendations thereon.
 - (e) The cost of implementing and carrying out the requirements of this subsection

shall be paid from funds collected pursuant to KRS 342.122.

- (6) The commissioner may promulgate administrative regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery or payment of medical services to employees receiving medical and related benefits under this chapter.
- (7) For purposes of this chapter, any medical provider shall charge only its customary fee for photocopying requested documents. However, in no event shall a photocopying fee of a medical provider or photocopying service exceed fifty cents (\$0.50) per page. However, a medical provider shall not charge a fee when the initial copy of medical records is provided to the injured worker or his or her attorney in response to a written request pursuant to KRS 422.317. In addition, there shall be no charge for reviewing any records of a medical provider, during regular business hours, by any party who is authorized to review the records and who requests a review pursuant to this chapter.
- (8)
 - (a) The commissioner shall develop or adopt practice parameters or evidence-based treatment guidelines for medical treatment for use by medical providers under this chapter, including but not limited to chronic pain management treatment and opioid use, and promulgate administrative regulations in order to implement the developed or adopted practice parameters or evidenced-based treatment guidelines on or before December 31, 2019. The commissioner may adopt any parameters for medical treatment as developed and updated by the federal Agency for Health Care Policy Research, or the commissioner may adopt other parameters for medical treatment which are developed by qualified bodies, as determined by the commissioner, with periodic updating based on data collected during the application of the parameters.
 - (b) The commissioner shall develop or adopt a pharmaceutical formulary for medications prescribed for the cure of and relief from the effects of a work injury or occupational disease and promulgate administrative regulations to implement the developed or adopted pharmaceutical formulary on or before December 31, 2018.
 - (c) Any provider of medical services under this chapter who has followed the practice parameters or treatment guidelines or formularies developed or adopted and implemented pursuant to this subsection shall be presumed to have met the appropriate legal standard of care in medical malpractice cases regardless of any unanticipated complication that may thereafter develop or be discovered.
- (9)
 - (a) Notwithstanding any other provision of law to the contrary, the medical fee schedule adopted under subsection (4) of this section shall require all worker's compensation insurance carriers, worker's compensation self-insured groups, and worker's compensation self-insured employers to provide coverage and payment for surgical first assisting services to registered nurse first assistants as defined in KRS 216B.015.
 - (b) The provisions of this subsection apply only if reimbursement for an assisting

physician would be covered and a registered nurse first assistant who performed the services is used as a substitute for the assisting physician. The reimbursement shall be made directly to the registered nurse first assistant if the claim is submitted by a registered nurse first assistant who is not an employee of the hospital or the surgeon performing the services.

Effective: June 29, 2021

History: Amended 2021 Ky. Acts ch. 124, sec. 5, effective June 29, 2021. -- Amended 2018 Ky. Acts ch. 40, sec. 2, effective July 14, 2018. -- Amended 2010 Ky. Acts ch. 24, sec. 1782, effective July 15, 2010. -- Amended 2007 Ky. Acts ch. 121, sec. 1, effective June 26, 2007. -- Amended 2005 Ky. Acts ch. 7, sec. 35, effective March 1, 2005. -- Amended 1996 Ky. Acts ch. 332, sec. 2, effective July 15, 1996; and ch. 355, sec. 5, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 181, Part 5, sec. 19, effective April 4, 1994. -- Amended 1987 (1st Extra. Sess.) Ky. Acts ch. 1, sec. 6, effective January 4, 1988. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 4886.

Legislative Research Commission Note (7/14/2018). This statute was amended in Section 2 of 2018 Ky. Acts ch. 40. Subsection (2) of Section 20 of that Act reads, "Sections 2, 4, and 5 and subsection (7) of Section 13 of this Act are remedial and shall apply to all claims irrespective of the date of injury or last exposure, provided that, as applied to any fully and finally adjudicated claim, the amount of indemnity ordered or awarded shall not be reduced and the duration of medical benefits shall not be limited in any way."

Legislative Research Commission Note (7/15/96). This section was amended by 1996 Ky. Acts chs. 332 and 355 which are in conflict. Under KRS 446.250, Acts ch. 332, which was last enacted by the General Assembly, prevails.

342.020 Medical treatment at expense of employer -- Duration of employer's obligation -- Continuation of benefits -- Selection of physician and hospital -- Payment -- Managed health care system -- Artificial members and braces -- Waiver of privilege -- Disclosure of interest in referrals -- Urine drug screenings -- Pharmacist services and procedures.

- (1) In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter for the length of time set forth in this section, or as may be required for the cure and treatment of an occupational disease.
- (2) In claims resulting in an award of permanent total disability or resulting from an injury described in subsection (9) of this section, the employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits.
- (3)
 - (a) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the employer's obligation to pay the benefits specified in this section shall continue for seven hundred eighty (780) weeks from the date of injury or date of last exposure.
 - (b) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the commissioner shall, in writing, advise the employee of the right to file an application for the continuation of benefits as described in this section. This notice shall be made to the employee seven hundred fifty-four (754) weeks from the date of injury or last exposure.
 - (c) An employee shall receive a continuation of benefits as described in this section for additional time beyond the period provided in paragraph (a) of this subsection as long as continued medical treatment is reasonably necessary and related to the work injury or occupational disease if:
 1. An application is filed within seventy-five (75) days prior to the termination of the seven hundred eighty (780) week period;
 2. The employee demonstrates that continued medical treatment is reasonably necessary and related to the work injury or occupational disease; and
 3. An administrative law judge determines and orders that continued benefits are reasonably necessary and related to the work injury or occupational disease for additional time beyond the original seven hundred eighty (780) week period provided in paragraph (a) of this subsection.
 - (d) If the administrative law judge determines that medical benefits are not reasonably necessary or not related to the work injury or occupational disease, or if an employee fails to make proper application for continued benefits within the time period provided in paragraph (c) of this subsection, any future medical treatment shall be deemed to be unrelated to the work injury and the

employer's obligation to pay medical benefits shall cease permanently.

- (4) In the absence of designation of a managed health care system by the employer, the employee may select medical providers to treat his injury or occupational disease. Even if the employer has designated a managed health care system, the injured employee may elect to continue treating with a physician who provided emergency medical care or treatment to the employee. The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered. Except as provided in subsection (7) of this section, in no event shall a medical fee exceed the limitations of an adopted medical fee schedule or other limitations contained in KRS 342.035, whichever is lower. The commissioner may promulgate administrative regulations establishing the form and content of a statement for services and procedures by which disputes relative to the necessity, effectiveness, frequency, and cost of services may be resolved.
- (5) Notwithstanding any provision of the Kentucky Revised Statutes to the contrary, medical services and treatment provided under this chapter shall not be subject to copayments or deductibles.
- (6) Employers may provide medical services through a managed health care system. The managed health care system shall file with the Department of Workers' Claims a plan for the rendition of health care services for work-related injuries and occupational diseases to be approved by the commissioner pursuant to administrative regulations promulgated by the commissioner.
- (7) All managed health care systems rendering medical services under this chapter shall include the following features in plans for workers' compensation medical care:
 - (a) Copayments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;
 - (b) The employee shall be allowed choice of provider within the plan;
 - (c) The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;
 - (d) The employee shall be allowed to obtain a second opinion, at the employer's expense, from an outside physician if a managed health care system physician recommends surgery;
 - (e) The employee may obtain medical services from providers outside the managed health care system, at the employer's expense, when treatment is unavailable through the managed health care system;
 - (f) The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the

frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee; and

- (g) Statements for services shall be audited regularly to assure that charges are not duplicated and do not exceed those authorized in the applicable fee schedules.
 - (h) A schedule of fees for all medical services to be provided under this chapter which shall not be subject to the limitations on medical fees contained in this chapter.
 - (i) Restrictions on provider selection imposed by a managed health care system authorized by this chapter shall not apply to emergency medical care.
- (8) Except for emergency medical care, medical services rendered pursuant to this chapter shall be under the supervision of a single treating physician or physicians' group having the authority to make referrals, as reasonably necessary, to appropriate facilities and specialists. The employee may change his designated physician one (1) time and thereafter shall show reasonable cause in order to change physicians.
- (9) When a compensable injury or occupational disease results in the amputation or partial amputation of an arm, hand, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, or permanent total or permanent partial paralysis, the employer shall pay for, in addition to the other medical, surgical, and hospital treatment enumerated in subsection (1) and this subsection, a modern artificial member and, where required, proper braces as may reasonably be required at the time of the injury and thereafter during disability.
- (10) Upon motion of the employer, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction of the administrative law judge by affidavits or testimony that, because of the physician selected by the employee to treat the injury or disease, or because of the hospital selected by the employee in which treatment is being rendered, that the employee is not receiving proper medical treatment and the recovery is being substantially affected or delayed; or that the funds for medical expenses are being spent without reasonable benefit to the employee; or that because of the physician selected by the employee or because of the type of medical treatment being received by the employee that the employer will substantially be prejudiced in any compensation proceedings resulting from the employee's injury or disease; then the administrative law judge may allow the employer to select a physician to treat the employee and the hospital or hospitals in which the employee is treated for the injury or disease. No action shall be brought against any employer subject to this chapter by any person to recover damages for malpractice or improper treatment received by any employee from any physician, hospital, or attendant thereof.
- (11) An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision in the Kentucky Revised Statutes, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care

provider shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer, special fund, uninsured employers' fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

- (12) When a provider of medical services or treatment, required by this chapter, makes referrals for medical services or treatment by this chapter, to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the commissioner, and the employer's insurer or the party responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.
- (13) (a) Except as provided in paragraphs (b) and (c) of this subsection, the employer, insurer, or payment obligor shall not be liable for urine drug screenings of patients in excess of:
1. One (1) per year for a patient considered to be low-risk;
 2. Two (2) per year for a patient considered to be moderate-risk; and
 3. Four (4) per year for patients considered to be high-risk;
- based upon the screening performed by the treating medical provider and other pertinent factors.
- (b) The employer, insurer, or payment obligor may be liable for urine drug screening at each office visit for patients that have exhibited aberrant behavior documented by multiple lost prescriptions, multiple requests for early refills of prescriptions, multiple providers prescribing or dispensing opioids or opioid substitutes as evidenced by the electronic monitoring system established in KRS 218A.202 or a similar system, unauthorized dosage escalation, or apparent intoxication.
- (c) The employer, insurer, or payment obligor may request additional urine drug screenings which shall not count toward the maximum number of drug screenings enumerated in paragraph (a) of this subsection.
- (d) The commissioner shall promulgate administrative regulations related to urine drug screenings as part of the practice parameters or treatment guidelines required under KRS 342.035.
- (14) (a) As used in this subsection, "practice of pharmacy" has the same meaning as in KRS 315.010.
- (b) In addition to all other compensation that may be reimbursed to a pharmacist under this chapter, the employer, insurer, or payment obligor shall be liable for the reimbursement of a pharmacist for a service or procedure at a rate not less than that provided to other nonphysician practitioners if the service or procedure:
1. Is within the scope of the practice of pharmacy;
 2. Would otherwise be compensable under this chapter if the service or procedure were provided by a:

- a. Physician;
 - b. Advanced practice registered nurse; or
 - c. Physician assistant; and
3. Is performed by the pharmacist in strict compliance with laws and administrative regulations related to the pharmacist's license.

Effective: June 29, 2021

History: Amended 2021 Ky. Acts ch. 30, sec. 6, effective June 29, 2021. -- Amended 2018 Ky. Acts ch. 40, sec. 1, effective July 14, 2018. -- Amended 2010 Ky. Acts ch. 24, sec. 1780, effective July 15, 2010. -- Amended 2000 Ky. Acts ch. 514, sec. 2, effective July 14, 2000. -- Amended 1996 (1st Extra. Sess.) Ky. Acts ch. 1, sec. 2, effective December 12, 1996. -- Amended 1996 Ky. Acts ch. 355, sec. 4, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 181, Part 5, sec. 17, effective April 4, 1994; and ch. 512, part 6, sec. 20, effective July 15, 1994. -- Amended 1992 Ky. Acts ch. 446, sec. 6, effective July 14, 1992. -- Amended 1987 (1st Extra. Sess.) Ky. Acts ch. 1, sec. 5, effective October 26, 1987. -- Amended 1972 Ky. Acts ch. 78, sec. 21. -- Amended 1970 Ky. Acts ch. 6, sec. 1. -- Amended 1964 Ky. Acts ch. 192, sec. 4. -- Amended 1960 Ky. Acts ch. 147, sec. 2. -- Amended 1956 Ky. Acts ch. 77, sec. 3. -- Amended 1952 Ky. Acts ch. 182, sec. 1. -- Amended 1950 Ky. Acts ch. 198, sec. 1. -- Amended 1948 Ky. Acts ch. 64, sec. 2. -- Amended 1946 Ky. Acts ch. 37, sec. 1. -- Recodified 1942 Ky. Acts ch. 208, sec. 1, effective October 1, 1942, from Ky. Stat. sec. 4883.

Legislative Research Commission Note (7/14/2018). This statute was amended in Section 1 of 2018 Ky. Acts ch. 40. Subsection (1) of Section 20 of that Act reads, "Sections 1, 3, and 12 of this Act shall apply to any claim arising from an injury or occupational disease or last exposure to the hazards of an occupational disease or cumulative trauma occurring on or after the effective date of this Act."